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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar CT myelogram

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that medical necessity for Lumbar CT myelogram is not established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury on xx/xx/xx when he was pinned between a gate injuring his low back. The patient is noted to have had a prior spinal fusion in 2012 with initial CT studies on the date of injury noting moderate degenerative disc disease and facet changes at L3-4 and L4-5. The patient did report complaints of radiating pain to the right posterior leg and foot. MRI studies of the lumbar spine from 01/15/14 noted marrow changes at L3-4 in the inferior L3 vertebral body with an osteophyte lateralizing to the right. There was a fracture at the superior end plate with protrusion of the nucleus into the superior portion of L4 with a small amount of marrow edema. No paraspinal fluid collection was evident. There was no evidence of retropulsed fragments at the L3-4 level. Some facet arthropathy without canal or foraminal stenosis at L4-5 was noted.

Radiographs of the lumbar spine completed on 08/20/14 noted a mild amount of retrolisthesis of L3 on L4 which appeared stable between flexion and extension views. There was some disc space narrowing noted at L3-4. The patient was evaluated on 08/20/14 with continuing complaints of severe low back pain with radiating pain to the buttock regions. The patient reported difficulty standing while upright. The patient's physical examination noted a stooped forward position with a slow and antalgic gait. Tenderness to palpation in the lumbar paravertebral musculature was noted with loss of lumbar range of motion in all planes. No motor weakness, reflex changes, or sensory deficits were noted. There was point tenderness in the lumbar L5-S1 facets with a positive straight leg raise to the right. Recommendations were for a therapeutic block to the right at L5-S1. The patient did have a psychological evaluation on 11/18/14 and was cleared for surgical intervention for a hardware removal surgery. There was a handwritten evaluation on 09/25/14 indicating that the patient was pending an epidural steroid injection with continuing complaints of low back pain as well as associated numbness and weakness in the lower extremities. No specific neurological findings were noted but paresthesia was reported in the bilateral lower extremities.

The requested CT myelogram study was denied by utilization review on 11/25/14 as there was no specific statement of a rationale for this study and there were no recent evaluations of the patient.

The request was again denied on 12/24/14 as there was lack of a sufficient rationale for supporting a CT myelogram study.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for continuing complaints of low back pain as a result of the crush injury reported on 01/07/14. MRI studies did note evidence of a fracture at L4 with a herniation of the disc at the L3-4 level. The last evaluation on 09/25/14 did recommended repeat MRI studies; however, there was no further rationale for CT myelogram studies in the clinical records. It does appear that the patient has been recommended for further surgical intervention to include a hardware removal. No updated evaluation was available for review further explaining the need for a CT myelogram study. Given the paucity of clinical information regarding a specific rationale for CT myelogram studies over the previously recommended MRI study of the lumbar spine, it is this reviewer's opinion that medical necessity for Lumbar CT myelogram is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)